

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

PLACE OF DEATH
County Buchanan

Township _____
or
Village _____
or
City St. Joseph

Registration District No. 85
Primary Registration District No. 1001

File No. 27951
Registered No. 897

(NO. Ashland Ave RR#3 St. _____ Ward _____)

(If death occurred in a hospital or institution, give its NAME instead of street and number)

FULL NAME Myrtle E. Oaks

PERSONAL AND STATISTICAL PARTICULARS

2 MEDICAL CERTIFICATE OF DEATH

SEX Female COLOR OR RACE White SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) Single

DATE OF DEATH Nov 13, 1911
(Month) (Day) (Year)

DATE OF BIRTH Nov 7, 1911
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Nov 7th, 1911, to Nov 11th, 1911, that I last saw her alive on Nov 10th, 1911, and that death occurred, on the date stated above, at 2:00 A.M.

AGE 7 yrs. 7 mos. 7 ds. If LESS than 1 day, ___ hrs. or ___ min.?

The CAUSE OF DEATH* was as follows:

OCCUPATION (a) Trade, profession, or particular kind of work _____

Insanition

(b) General nature of industry, business, or establishment in which employed (or employer) _____

BIRTHPLACE (City or town, State or foreign country) St. Joseph Mo.

About a week (Duration) yrs. mos. 7 ds.

NAME OF FATHER Alex Oaks

Contributory Poor Condition of Mother (SECONDARY) (Duration) yrs. mos. ds.

BIRTHPLACE OF FATHER (City or town, State or foreign country) Canada

(Signed) S. F. Kessler M. D. Nov 12, 1911 (Address) St. Joseph Mo

MAIDEN NAME OF MOTHER Hattie Saul

*State the Disease Causing Death, or, in Deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

BIRTHPLACE OF MOTHER (City or town, State or foreign country) New York

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death ___ yrs. ___ mos. ___ ds. In the State ___ yrs. ___ mos. ___ ds.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) John E. Madrigal (ADDRESS) #RR3 Ashland Ave

Where was disease contracted if not at place of death? Former or usual residence _____

Filled Nov 13, 1911 M. B. Keeling REGISTRAR

PLACE OF BURIAL OR REMOVAL Ashland Cem. DATE OF BURIAL Nov 13, 1911
UNDERTAKER R. Meierhoff ADDRESS 824 Tulsa

N. B.—Every item of information should be carefully checked and verified before being reported. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

Revised United States Standard Certificate of Death

[Approved by U. S. Census and American Public Health
Association]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sar-*

coma, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septichaemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, OR HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)



MISSOURI STATE BOARD OF HEALTH

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

PLACE OF DEATH
County Buchanan
Township _____
or
Village _____
or
City St Joseph (NO. _____ St. _____ Ward _____)

Registration District No. 85 File No. _____
Primary Registration District No. 1001 Registered No. 897

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME Myrtle E. Oars

PERSONAL AND STATISTICAL PARTICULARS

SEX M COLOR OR RACE W SINGLE MARRIED WIDOWED OR DIVORCED Single
(Write the word)
DATE OF BIRTH 11-7, 1911
(Month) (Day) (Year)
AGE _____ yrs. _____ mos. _____ ds. IF LESS than 1 day, _____ hrs. or _____ min.

OCCUPATION
(a) Trade, profession, or particular kind of work _____
(b) General nature of industry, business, or establishment in which employed (or employer) _____

BIRTHPLACE
(City or town, State or foreign country) Boys

PARENTS
NAME OF FATHER Alfred Oars
BIRTHPLACE OF FATHER (City or town, State or foreign country) Canada
MAIDEN NAME OF MOTHER Esther Smith
BIRTHPLACE OF MOTHER (City or town, State or foreign country) N.Y.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. E. Mahinger
(ADDRESS) R.R. #3

Filed Jan 2 1911 M. B. Kelling REGISTRAR

Original file, date NOV 1911

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH 11-13, 1911
(Month) (Day) (Year)
I HEREBY CERTIFY, that I attended deceased from _____, 1911, to _____, 1911,
that I last saw her alive on 11-10, 1911,
and that death occurred, on the date stated above, at _____ a.m.

The CAUSE OF DEATH* was as follows:
Probably Tuberculosis X
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(Duration) _____ yrs. _____ mos. _____ ds.

Contributory Por condition mother
(SECONDARY) (Duration) _____ yrs. _____ mos. _____ ds.
(Signed) J. F. Newberry M. D.
Jan 2 1911 (Address) St Joseph

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.
Where was disease contracted if not at place of death? _____
Former or usual residence _____

PLACE OF BURIAL OR REMOVAL St Joseph DATE OF BURIAL 11-13 1911
UNDERTAKER R. Merckhoff ADDRESS 824 Felix

All information called for must be written on this Supplementary Certificate.

Revised United States Standard Certificate of Death

[[Approved by U. S. Census and American Public Health Association]

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37951
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